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STATE OF NORTH CAROLINA

COUNTY OF PASQUOTANK

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 DHR 01747

Rashawna Williams Health and Human Service Registery Petitioner, v. NC Department of Health & Human Services Divison of Health Service Regulation Respondent.	**FINAL DECISION**

THIS CONTESTED CASE came on for hearing before the Honorable Karlene S. Turrentine, Administrative Law Judge, on November 17, 2022, in Ayden, Pitt County, North Carolina, pursuant to N.C.G.S. § 150B-23 and Petitioner's contested case petition appealing Respondent's decision to place her name on the Health Care Personnel Registry with findings of neglect and abuse, pursuant to N.C.G.S. § 131-E-256.

THE PARTIES

The parties to this contested case are the Petitioner Rashawna Williams (herein, "Petitioner" or Ms. Williams) and Respondent NC Department of Health and Human Services, Division of Health Service Regulation (herein, "Respondent", "DHHS" or "Respondent-HSR").

APPEARANCES

For Petitioner: Petitioner Rashawna Williams appeared *pro se*

For Respondent: William F. Maddrey
Assistant Attorney General
NC Department of Justice
Attorney for Respondent DHHS

WITNESSES

For Petitioner:

The Petitioner presented testimony from the following witnesses: Shanae Driver, Medical Technician, sometimes Supervisor in Charge and Personal Care Assistant; Nicole Williams, Lead Supervisor; and Regina Lightfoot, Medication Aid and Supervisor in Charge.

For Respondent:

The Respondent presented testimony from the following witnesses: Petitioner Rashwna Williams and, Elizabeth Skinner, Registered Nurch, Nurse Consultant I.

EXHIBITS

For Petitioner:

EXHIBIT NO.	PETITIONER'S EXHIBITS ADMITTED WITHOUT OBJECTION
1	DHHS Health Service Regulation Complaint Intake & Health Care Personnel Investigations Section's **Interview with Michelle Bollinger**
2	DHHS Health Service Regulation Complaint Intake & Health Care Personnel Investigations Section's **Interview with Melissa Lyons**
3	Character letter re: Petitioner, by Hope Johnson, RN, BSN
4	Character letter re: Petitioner, by Mary Berry, AGNP

EXHIBIT NO.	RESPONDENT'S EXHIBITS ADMITTED AS NOTED BELOW
1	DHHS Health Service Regulation Complaint Intake & Health Care Personnel Investigations Section's **Investigation Conclusion Report** (1/19/2022 – 4/13/2022)—NO OBJECTION
2	DHHS Health Care Personnel Registry Section **Entry of Finding**—ADMITTED OVER OBJECTION BY PETITIONER
3	DHHS' **January 19, 2022 Certified Letter** to Petitioner RE: Listing of an Allegation into the Health Care Personnel Registry, **April 13, 2022 Certified Letter** to Petitioner RE: Additional Pending Allegations to be Investigated & **April 14, 2022 Certified Letter** to Petitioner RE: Entry of Findings into the Health Care Personnel Registry—NO OBJECTION
4	Resident Register including Certain Medical Records of Resident JK—ADMITTED AFTER REDACTION WITHOUT OBJECTION
6	Affinity Living Group's **Resident Abuse, Neglect and Exploitation Policy**—ADMITTED OVER OBJECTION OF PETITIONER
7	Affinity Living Group's **Resident Bill of Rights**—NO OBJECTION
8	DHHS Complaint Intake & Health Care Personnel Investigations **Initial Allegation Report** & **Investigation Report**—NO OBJECTION
9	DHHS Health Service Regulation Complaint Intake & Health Care Personnel Investigations Section's **Interview with Petitioner Rashawna Williams**—NO OBJECTION

ISSUE

Whether Respondent deprived Petitioner of property or otherwise substantially prejudiced Petitioner's rights *and* exceeded its authority or jurisdiction, acted erroneously, failed

to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated an allegation that, on or about December 20, 2021, that Petitioner abused and neglected a resident at Currituck House in Moyock, North Carolina, by willfully grabbing the resident's arm, resulting in physical harm and pain, and by failing to appropriately intervene with the resident necessary to avoid physical harm and pain. *See* Resp. Exh 1, Investigation Conclusion Report, p.1.

BURDEN OF PROOF

Pursuant to N.C.G.S. 150B-25.1, the burden of proof in this contested case is on the Petitioner.

APPLICABLE STATUTES AND REGULATIONS

N.C. Gen. Stat. § 150B *et seq.*
N.C. Gen. Stat. § 131E, Article 15 *et seq.*
10A NCAC 13O .0101 & .0102
42 C.F.R. § 488.301

UPON CAREFUL CONSIDERATION of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact and conclusions of law. In making the findings of fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including, but not limited to, the demeanor of the witness, any interests, bias, or prejudice the witnesses may have, the opportunity of the witnesses to see, hear, know or remember the facts or occurrences about which the witnesses testified, whether the testimony of the witnesses is reasonable, and whether the testimony is consistent with all other believable evidence in the case. Based on the above, the Undersigned makes the following:

FINDINGS OF FACT

1. This contested case arose from Petitioner's appeal of Respondent's investigating and substantiating an allegation that Petitioner abused and neglected a resident of the Currituck House in Moyock, NC on December 20, 2021 ("the incident"), and listing a substantiated finding of neglect and abuse against Petitioner on the North Carolina Health Care Personnel Registry. *See* Resp. Exh. 1, p.1, Resp. Exh. A, attached to Respondent's Prehearing Statement ("PHS"), filed June 13, 2022.

2. Pursuant to N.C.G.S. § 131E-256(a)(1) and federal law, Respondent is charged with the obligation of maintaining the Health Care Personnel Registry ("the Registry") with the names of all unlicensed health care personnel who have findings substantiated against them that they abused, neglected, or exploited a resident while working in a NC health care facility. *Keller by & through Keller v. Deerfield Episcopal Ret. Cmty., Inc.,* 271 N.C. App. 618, 626, 845 S.E.2d 156, 162 (2020).

3. Currituck House, as an adult care home, is a "health care facility" for purposes of the North Carolina Health Care Personnel Registry. N.C.G.S. § 131E-256(b)(1); *See also* N.C.G.S. § 131D-2.1(3).

4. At the time of the incident and, at all times relevant to this matter, Petitioner was employed as a Personal Care Aide at Currituck House ("facility") and, as such, was "health care personnel," in that Petitioner was unlicensed staff of a health care facility having direct access to a resident or client of the facility. N.C.G.S. § 131E-256(c).

5. Petitioner has worked for the facility for four years. Resp. Exh. 9, p.2, ¶2.

6. Petitioner's job duties included assisting residents with daily living activities and personal care whenever needed. *Id.* at ¶3.

7. The facility gave Petitioner training "on Resident Rights, Abuse and Neglect"; however, it is unclear whether that training occurred *prior to* or *after* she had been accused of abuse and neglect. *Id.* at ¶6.

8. At all times relevant to this matter:

a) Shanae Driver was a coworker of Petitioner at the facility;

b) Nicole Williams was a coworker of Petitioner at the facility and her sister;

c) Regina Lightfoot was a coworker of Petitioner at the facility; and,

d) Elizabeth Skinner was a Nurse Consultant for Respondent.

9. As a Nurse Consultant for HSR, Elizabeth Skinner performed health care personnel investigations for the State. Ms. Skinner has an educational background in nursing and has been a nurse for over twenty-seven years. It was her job to look at cases and determine whether the allegations received needed to be investigated.

10. JK[1] was an elderly resident in the facility[2]. At the time of the incident JK had been diagnosed with Parkinson's disease and muscle weakness and was in hospice care in the facility. JK could follow some instructions but needed a great deal of assistance. He needed to be bathed and, though at times he could feed himself, often he could not. Shanae Driver's testimony.

11. JK had a habit of grabbing the railing and holding on. (The facility considered this a "behavior[al]" issue.) However, due to the Parkinson's disease, his muscles would tighten

[1] To protect the privacy of the resident, the Undersigned has utilized these initials for the resident.
[2] JK died of natural causes before Respondent completed its Investigation Conclusion Report on April 13, 2022. *See* Resp. Exh. 1, pp.1, 9.

such that sometimes, he could not readily let go. Resp. Exh. 9, p.2, ¶14. *See also* Regina Lightfoot's testimony.

12. Petitioner was a caregiver to JK. However, Petitioner was *never* JK's sole care provider. Shanae Driver's testimony.

13. Petitioner testified credibly that when JK had behavioral issues, she "would talk to him [and] give him time." Resp. Exh. 9, p.2, ¶16 and, Petitioner's testimony.

14. On January 5, 2022 at 3:15 p.m., Respondent-HSR conducted a survey of Currituck House as a result of which it reported an allegation to Respondent that Petitioner had **abused** a resident by "talking down to and handling the resident roughly. [Moreover, Respondent-] HSR reported [an] allegation of resident being grabbed by the arm causing bruising. Photos of [the] injury were provided to DHHSR by an outside agency." Resp. Exh. 8, Investigation Report, p.2, §§ C & D.

15. On January 19, 2022, Respondent issued notice (mailed certified) to Petitioner that there was an "allegation that [Petitioner] abused a resident of Currituck House in Moyock. …The Department has determined that an investigation is to be conducted of the allegation that on or about January 5, 2022 you abused a resident at Currituck House." Resp. Exh. 3, January 19, 2022 letter, p.1 (emphasis added).

16. In its April 13, 2022 certified mailing to Petitioner, Respondent noticed Petitioner that "As you know, the Department is currently investigating an allegation that, on or about January 5, 2022, you abused a resident at Currituck House. During the course of this investigation, the following additional allegation(s) against you have been reported to the Department: [that o]n or about January 5, 2022, [Petitioner] neglected a resident at Currituck House." Resp. Exh. 3, April 13, 2022 letter, p.1 (emphasis added).

17. Then, on April 14, 2022, Respondent issued notice of its Final Agency Action via certified mail to Petitioner advising her that "The Department has investigated and substantiated the…allegations []" of abuse and neglect against her and stating her appeal rights. Resp. Exh. 3, April 14, 2022 letter, p.1.

18. Respondent's Final Agency Action notice states there were "allegations that [Petitioner] neglected a resident and abused a resident […and that t]he Department…investigated and substantiated [those] allegations." However, **neither** Respondent's Investigator's interview with Petitioner on March 10, 2022 **nor** Respondent's Personnel Investigation Conclusion Report mentions any allegation of neglect made against Petitioner. Resp. Exh. 3, April 14, 2022 letter, p.1.; s*ee also* Resp. Exhs. 1, 8 and, 9.

19. There is *no evidence* in the record of how Respondent settled on the date of December 20, 2021 as being the date the injury occurred. However, Ms. Skinner testified to the 'certainty' of that date.

20. As part of her investigation, Ms. Skinner interviewed staff members of the facility and Petitioner; reviewed Petitioner's personnel file; reviewed JK's medical records; and, reviewed the facility's investigation documentation. Resp. Exh 1. Ms. Skinner also called the Sheriff's Office, but the incident had not been reported to them. *Id.* at p.19.

21. In her interview with Ms. Skinner, Petitioner denied any abuse of JK. She stated that the allegations arose from two (2) employees who lied about her (the facility's Activity Director and the Business Office Manager) Petitioner advised Ms. Skinner she had had a spat with the Activity Director a while back and the woman lied about her then and gathered others to lie about her as well.

> "[These are t]he same allegations with the same people that lied about me the first time [back in November 2021]. …I [sic] was unsubstantiated before. When I was suspended over a month, resident JK had bruises on him and I wasn't even there. How could they say I did something? The same people keep lying…. They tried to say I did something, but their story kept falling in. Because it wasn't true."

Resp. Exh. 1, p.16.

22. Ms. Skinner testified that the incident in November 2021 was unsubstantiated against Petitioner. Respondent's documentation of record confirms that.

23. At trial, Petitioner credibly denied *ever* abusing JK or any facility resident. She again stated the allegations were falsified by Michelle Bollinger, the Activity Director and Melissa Lyons, the Business Office Manager—the same two (2) employees who had alleged Petitioner abused JK back in November 2021.

24. Ms. Skinner testified that Petitioner was "substantiated for abuse and neglect" against JK (in the December 2021 incident) because "she grabbed the resident's arm in an attempt to remove his hand from the handrail." Elizabeth Skinner's testimony. However, in the Closing Statement of her Investigation Conclusion Report, Ms. Skinner wrote: "There was sufficient evidence to substantiate the allegation that on or about 12/20/2021, Rashawna Williams, a Health Care Personnel, abused a resident (JK) at Currituck House, by willfully grabbing the resident's arm, resulting in physical harm and pain." Resp. Exh. 1, p.20.

25. There is no admissible evidence that Petitioner grabbed JK's arm and, there is no evidence that JK was either injured (harmed) by Petitioner or experienced pain therefrom.

26. Respondent's only witness at trial was Ms. Skinner and she had no personal knowledge of the incident in question. All that Ms. Skinner asserted knowing about the incident she learned from interviewing others. There was no testimony at trial from anyone stating they either saw what happened or had any personal knowledge of the alleged incident. Neither Ms. Bollinger nor Ms. Lyons testified.

27. Out of those who did testify, none observed the incident which resulted in the alleged abuse. In fact, none of Respondent's documentation reflects there was *any* eyewitness to the alleged incident.

28. More importantly, Respondent failed to present evidence that Petitioner was even at work on December 20, 2021. To the contrary, Petitioner testified that she always took off around her birthday (December 21st) and that testimony was corroborated by Ms. Driver.

29. Ms. Skinner testified that her decision to substantiate the allegations against Petitioner was based on information provided to her by other persons. Yet, none of those other persons testified at trial.

30. There was no evidence at trial to support Ms. Skinner's determination that Petitioner had abused or neglected JK.

BASED ON the foregoing Findings of Fact, the Tribunal makes the following:

CONCLUSIONS OF LAW

1. The North Carolina Office of Administrative Hearings has jurisdiction over the parties and subject matter of this contested case. N.C.G.S. 131E and 150B.

2. All parties have been correctly designated and there is no question of misjoinder or nonjoinder.

3. Notice of Hearing was provided to all parties in accordance with N.C.G.S. 150B-23(b).

4. Petitioner has the burden of proof to establish as factual that Respondent deprived her of property or otherwise substantially prejudiced Petitioner's rights *and* exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated an allegation that, on or about December 20, 2021, that Petitioner abused and neglected JK, a resident, at Currituck House in Moyock, North Carolina:

> "In appeals under § 150B–23(a), the statute requires a petitioner, other than an agency, to allege facts establishing that the agency acted improperly in order to state a proper basis for obtaining relief from the agency decision. Under *Peace,* because the petitioner is seeking to show a basis for reversing the agency decision, the burden of proof is properly allocated to the petitioner—even if that burden requires proving a negative."

Overcash v. N. Carolina Dep't of Env't & Nat. Res., Div. of Waste Mgmt., 179 N.C. App. 697, 704–05, 635 S.E.2d 442, 447–48 (2006).

5. To the extent that the Findings of Fact contain Conclusions of Law, and vice versa, they should be so considered without regard to their given labels. *Charlotte v. Heath*, 226 N.C. 750, 755, 440 S.E.2d 600, 604 (1946). A court or other hearing authority need not make findings as to every fact that arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612, aff'd, 335 N.C. 234, 436 S.E.2d 588 (1993).

6. " Hearsay is 'a statement, other than one made by the declarant while testifying at trial or hearing, offered in evidence to prove the truth of the matter asserted. Our State's APA provides that in all contested cases, "[e]xcept as otherwise provided, the rules of evidence as applied in the trial division of the General Court of Justice shall be followed; but, when evidence is not reasonably available under the rules to show relevant facts, then the most reliable and substantial evidence shall be admitted." See *North Carolina Department of Public Safety v. Ledford*, 246 N.C. App. 266, 291 (2016) citing N.C. Gen. Stat. § 8C–1, Rule 801 (2015), N.C. Gen. Stat. § 150B–29(a).

7. Moreover, it is both within the Administrative Law Judge's duty to determine the weight and sufficiency of the evidence and the credibility of the witnesses, and authority to determine whose testimony the Tribunal may and should accept or reject in whole or in part, as well as determining any inferences to be drawn from the facts. *Id*. at 299, citing *City of Rockingham v. North Carolina Department of Environmental and Natural Resources Division of Water,* 224 N.C.App. 228, 239 (2012).

8. Our General Assembly set forth particular laws with which Respondent must comply when health care personnel are accused of malfeasance, specifically: "The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have: …Been accused of any of the acts listed in subdivision (1) of this subsection…." N.C.G.S. § 131E-256(a)(2).

9. Under subdivision (1) of the referenced subsection of the statute, "[n]eglect or abuse of a resident in a health care facility…" is listed so that the Department is statutorily required to maintain a health care personnel registry containing the names of any health care personnel accused of neglect or abuse of a resident in a health care facility. N.C.G.S. § 131E-256 (a)(1).

10. Moreover, "[f]or the purpose of this section," adult care homes (such as Currituck house) are considered to be "health care facilities[.]" N.C.G.S. 131E-256(b)(1). Further, "the term 'health care personnel' means any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment has the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided." N.C.G.S. § 131E-256(c).

11. Abuse is the "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the

deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." 10A N.C.A.C. 13O.0101(1), 42 CFR § 488.301.

12. "[I]nstances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish." However, the admissible evidence must show an actual "instance of abuse." 42 C.F.R. 488.01.

13. There was no evidence presented that Petitioner abused JK as there was no admissible evidence of an actual "instance of abuse" by Petitioner.

14. The facts of this case reveal that while HSR was at the facility doing an unrelated survey, one (1) or two (2) facility employees alleged Petitioner abused JK weeks before. Nothing in the record supports that either of the employees reporting the abuse actually saw it occur, and; although Ms. Skinner reported there were photographs of the injury resulting therefrom, neither the photos nor any indication of who took them or when they were taken is in the reflected in the record. Thus none of the evidence, upon which Respondent based its substantiation that Petitioner abused JK, is reliable.

15. There also was no evidence presented that Petitioner neglected JK.

16. All the findings and conclusions in Ms. Skinner's Investigation Conclusion Report, which even lean toward wrongdoing by Petitioner, are hearsay and, as such are inadmissible. Further, there was no competent evidence presented at trial either to support the Report or to corroborate it.

17. Accordingly, the admissible evidence in this case does not support Respondent's conclusion that Petitioner at any time abused JK. Petitioner met her burden of proof by showing Respondent deprived her of her job and exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated the allegation of abuse against her based on nothing but unreliable hearsay. *See Overcash, supra.*

18. Neglect is "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." 10A N.C.A.C. 13O .0101(10); 42 CFR § 488.301. This definition is incorporated into North Carolina rules at 10 N.C.A.C. 13O.0101. This definition requires evidence that the services that were not provided by the accused health care personnel were necessary "to avoid physical harm" and the other consequences referenced in the rule. Pamela Byrd v. North Carolina Department of Health and Human Services, 13 DHR 12691 (2013)

19. As with abuse, the admissible evidence in this case does not demonstrate that Petitioner neglected JK at any time.

20. There is no evidence that Petitioner bruised JK or that JK experienced bruising, pain, mental anguish, or emotional distress.

21. Accordingly, Petitioner met her burden of proof by showing Respondent deprived her of her job and exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule when it substantiated the allegation of neglect against her based on nothing but unreliable hearsay. *See Overcash, supra.*

22. Petitioner satisfied her burden of proving that Respondent substantially prejudiced Petitioner's rights, failed to act as required by law or rule, exceeded its authority and failed to use proper procedure when Respondent substantiated the allegations of abuse and neglect against Petitioner arising from the incident on or about December 20, 2021 and/or January 5, 2022 (as Respondent's own date of the incident differs in various places in its documentation.

23. Petitioner's name must be removed from the Health Care Personnel Registry. *Pamela Byrd v. North Carolina Department of Health and Human Services*, 13 DHR 12691 (2013).

FINAL DECISION

IT IS ORDERED, ADJUDGED & DECREED that Respondent's Final Agency Action is hereby **REVERSED**. Respondent shall remove Petitioner's name from the North Carolina Health Care Personnel Registry and the records of the North Carolina Health Care Personnel Registry shall reflect that the allegations of abuse and neglect by Petitioner were not established.

NOTICE OF APPEAL

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision**. In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties as indicated by the Certificate of Service attached to this Final Decision**. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case

with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

SO ORDERED. This the 2nd day of February, 2023.

Hon. Karlene S. Turrentine
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

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This the 2nd day of February, 2023.

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